

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11710

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River, USNAS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USNAS</b>				d. STREET ADDRESS <b>711A MEMQ</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Arrious Merrill BURNHAM</b>				4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1930</b>		9. AGE (In years last birthday) <b>28</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Air Controlman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Utah</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leland Adelbert Burnham</b>				14. MOTHER'S MAIDEN NAME <b>Unobtainable - deceased.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>10/47 to 10/58 529 32 6277</b>		17. INFORMANT <b>U.S. Navy Records, USNAS, Patuxent River, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976X</b> DUE TO <b>WOUND, MISSILE, Gunshot (Shotgun) Left Chest</b>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Artery and Nerve Involvement</b>  (c) _____</p> </div> <div style="width: 45%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted gunshot wound.</b>					
20c. TIME OF INJURY Hour <b>8:00</b> AM <b>xx</b> Oct <b>22</b> 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>		20f. (City or town) <b>USNAS</b> (County) _____ (State) _____ <b>Patuxent River, St. Marys, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . <b>J. E. PYEATTE, LT MC USNR, USNAS, Patuxent River, Md. 10-22-58.</b>							
ACTUAL SIGNATURE <i>[Signature]</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>WM. D. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/27/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR <b>OCT 30 58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Huns</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD STATE DEPARTMENT OF HEALTH - BIRMINGHAM  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
John William		35		Male		White		October 22, 1918	
Place of Birth		Occupation		Cause of Death		Manner of Death		Signature of Examiner	
New York City		Carpenter		Typhoid Fever		Natural		J. H. Smith	
Residence		Date of Admission		Date of Discharge		Date of Death		Date of Burial	
123 Main St.		October 1, 1918		October 15, 1918		October 22, 1918		October 25, 1918	
Hospital		Physician		Nurse		Burial Place		Burial Date	
St. Mary's		Dr. J. H. Smith		Miss M. J. Brown		St. Mary's Cemetery		October 25, 1918	
Remarks		Disposition of Body		Disposition of Organs		Disposition of Bones		Disposition of Hair	
Autopsy performed		Buried		Preserved		Cremated		None	

11717

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth N. Byler</b>		4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/ 11/ 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Christian Zook</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Hanagy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Moses Byler - Mechanicsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes &amp; hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>55</b> , to <b>Oct</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>22 Oct</b> , 19 <b>58</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leon A Berube</b> M.D.		ADDRESS (Street, city or town, state) <b>Mechanicsville, Md</b> DATE SIGNED <b>10/22/58</b>	
PHYSICIAN'S NAME (Type) <b>Leon Berube MD</b>		<b>Mechanicsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/25/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Amish Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mechanicsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 30 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11712

Reg. Dist. No.

FOR STATE  
HEALTH DEPT

11718

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>state highway, Great Mills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Willie James Caple</b>		4. DATE OF DEATH Month <b>October</b> Day <b>25</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4; 1919</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>warehouseman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Van Line</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Madeline Caple- Lexington Park, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Cervical Spine + Multiple Crushing injuries</b> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>Instant.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>was standing in road in front of car when hit by auto.</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:50 p.m. 10-25-58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Horse Head Rd</b>	20f. (City or town) (County) (State) <b>Great Mills AT May Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W.D. Beyle</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Wm. D. Boyd, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/30/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Red Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wadesboro, North Carolina.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 30 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

raise another

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG235 11-10-58 et

11719

## CERTIFICATE OF DEATH

Reg. Dist. No. 11713

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>7days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Piney Point</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Benjamin Rudolph Goddard</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>Oct. 31, 1958</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July 18, 1872</b>	<b>9. AGE</b> (In years last birthday) <b>86</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>3</b> Days <b>13</b> Hours <b></b> Min. <b></b>	<b>IF UNDER 24 HRS.</b> Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Self</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Benjamin Goddard</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Maria Evans</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Mrs Lucy Lumpkin, Piney Point, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Asthma + Myocarditis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>493X</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from Oct 24, 1958 to Oct 31, 1958 that I last saw the deceased alive on Oct 31, 1958, and that death occurred at 9 P. M. from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <b>Charles Greenwell</b>		<b>M.D.</b> <b>Leonardtwn</b>		<b>ADDRESS</b> (Street, city or town, state) <b>7nd</b>		<b>DATE SIGNED</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>Charles Greenwell M.D.</b>		<b>Leonardtwn, Maryland</b>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>11/3/58</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>ST. George Episcopal</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Valley Lee, Md.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>W. Clarke Mattingley Leonardtown, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> DATE <b>NOV 5 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11720

Item 1 Film G235 11-3-58 et

## CERTIFICATE OF DEATH

11714

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>3hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Allen</b> Middle <b>E</b> Last <b>Hammett</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>24</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1915</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>California, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George David Hammett</b>		14. MOTHER'S MAIDEN NAME <b>Minnie B. Watts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 11 579-12-6879</b>	
17. INFORMANT <b>Helen M. Hammett</b>		Address <b>Park Hall, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage.</b> <b>330X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 23</b> , 19 <b>58</b> , to <b>Oct 24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct. 24</b> , 19 <b>58</b> , and that death occurred at <b>2:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William H. Patrick</b>		ADDRESS (Street, city or town, state) <b>Lexington Park, Md.</b>	
PHYSICIAN'S NAME (Type) <b>William H. Patrick M.D.</b>		DATE SIGNED <b>10-26-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/27/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Face</b>		22d. LOCATION (City, town, or county) (State) <b>Great Mills, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct 28 58</b>		DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		DATE	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 1 FilmG235 10-24-58 et

## CERTIFICATE OF DEATH

11715

11721

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>St. George Island</u>		<u>4 yrs.</u>		TOWN <u>Rural Mechanicsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Poe's Nursing Home</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Edith</u>		(Middle) <u>Hayden</u>		(Last)			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Feb. 7, 1874</u>	
9. AGE last birthday <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George M. Hayden</u>				14. MOTHER'S MAIDEN NAME <u>Knott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS <u>Mrs Will Turner Mechanicsville, Md.</u>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
422.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>Oct 16 19 58</u> to <u>Oct 16 19 58</u> , that I last saw the deceased alive on <u>Oct 16 19 58</u> , and that death occurred at <u>10:18 58</u> M., from the causes and on the date stated above.							
SIGNATURE <u>W.H. Patrick</u>				ADDRESS (Street, city, town, state) <u>P.R. Lexington Park</u>			
DATE <u>10-18-58</u>				DATE SIGNED <u>10-18-58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/20/58</u>		NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		LOCATION (City, town, or county) (State) <u>Leonardtown, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kress</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u> ADDRESS <u>Leonardtown, Md.</u>			

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may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11722

CERTIFICATE OF DEATH

11716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>St Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Francis Leo Holly</u>		4. DATE OF DEATH <u>Oct. 10 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1937</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>21</u> yrs. <u>1</u> month <u>20</u> days
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Francis Leo Holly Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary H. Butler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>L</u>	
17. INFORMANT <u>Leo Holly Sr.</u>		Address <u>Leonardtown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X PNEUMONIA</u> DUE TO (b) <u>PNEUMONIA &amp; ENTERITIS</u> DUE TO (c) <u>lying cause last.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>OCT 8</u> , 19 <u>58</u> , to <u>OCT 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>OCT. 10</u> , 19 <u>58</u> , and that death occurred at <u>8</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Greenwell</u>		ADDRESS (Street, city or town, state) <u>Leonardtown Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>CHARLES GREENWELL, M.D.</u>		<u>LEONARDTOWN, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-11-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady's</u>	22d. LOCATION (City, town, or county) (State) <u>Medley Neck Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McLark Mattingly</u>		24. REC'D BY REGISTRAR <u>Oct 14 1958</u>	
ADDRESS <u>Leonardtown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

CERTIFICATE OF DEATH

11953

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

11953

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11-20

Aug. 21/1951

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John Thomas Lee  
11-20  
11-20

11-20

11-20

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11717

11723

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b>			c. LENGTH OF STAY IN 1b <b>3 1/2 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>D.O.A. Patuxent River USNASH</b>				d. STREET ADDRESS <b>Hill's Trailer Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ellen Alicia Kuhn</b>				4. DATE OF DEATH Month Day Year <b>October 1 1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 17, 1958</b>		9. AGE (In years lost birthday) yrs. Months Days Hours Min. <b>3 13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Perry Kuhn, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Shelby Jean Wood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Father: E.P. Kuhn, Jr.</b> <b>Great Mills, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dead on arrival at Station Hospital, U. S. Naval Air Station, Patuxent River, Maryland at 7:50 a.m. 10-1-58</b> alive on _____, and that death occurred at _____, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James P. Zettas</b> M.D.				ADDRESS (Street, city or town, state) <b>U. S. Naval Air Station,</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>JAMES P. ZETTAS, LT MC USNR</b>				Patuxent River, Maryland 10-1-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/3/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Face</b>		22d. LOCATION (City, town, or county) (State) <b>Great Mills, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. B. Robinson - Leonardtown, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>OCT 6 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>			

2051192XV3

CERTIFICATE OF DEATH

11723

NAME OF DECEASED Mary Ellen		AGE 34		SEX Female		RACE White		DATE OF BIRTH June 14, 1889		PLACE OF BIRTH Maryland	
RESIDENCE 11111		OCCUPATION None		CAUSE OF DEATH None		MANNER OF DEATH None		DATE OF DEATH June 14, 1923		PLACE OF DEATH Maryland	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF FUNERAL HOME None		NAME OF BURIAL PLACE None		NAME OF CEMETERY None		NAME OF MINISTER None		NAME OF CHURCH None	
NAME OF NEXT OF KIN John Smith		NAME OF WITNESS None		NAME OF SECOND WITNESS None		NAME OF THIRD WITNESS None		NAME OF FOURTH WITNESS None		NAME OF FIFTH WITNESS None	
NAME OF REGISTRAR J. H. Smith		NAME OF CLERK None		NAME OF ASSISTANT CLERK None		NAME OF DEPUTY CLERK None		NAME OF DEPUTY REGISTRAR None		NAME OF DEPUTY CLERK None	

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11718

11724 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Mechanicsville</b>		LENGTH OF STAY (In this place) <b>D.O.A.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>X TOWN Rural Clements</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>Andrew</b>		(Middle) <b>Clarence</b>		(Last) <b>Latham</b>		(Month) <b>Oct. 14,</b> (Day) <b>19</b> (Year) <b>58</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Nov. 7, 1875</b>	<b>9. AGE last birthday</b> <b>82</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>11</b> Days <b>14</b>	<b>IF UNDER 24 HRS.</b> Hours <b>14</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Clements, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>William E. Latham</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Helen Moran</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Charles Z. Latham Leonardtown, Md</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b> <b>Coronary Thrombosis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1/2 hr</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Arteriosclerotic cardiovascular disease</b>				<b>10 yrs</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan 1, 1950, to Oct 14, 1958, that I last saw the deceased alive on Oct 14, 1958, and that death occurred at 5:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>W. Roy Gopher</i>		<b>M.D.</b> <i>Mechanicsville</i>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b> <i>10/14/58</i>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>10/17/58</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Joseph's</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Morganza, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>OCT 20 '58</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Charles Z. Latham</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Clarke Mattingley Leonardtown, Md.</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11719

Reg. Dist. No.

11725

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Callaway</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Georges Island</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>State Highway</b>			/d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Janet Marie Milburn</b>			4. DATE OF DEATH <b>10 / 13 / 19 58</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/29/1956</b>		9. AGE (in years last birthday) <b>2</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John R. Milburn</b>			14. MOTHER'S MAIDEN NAME <b>Georgia M. Barnes</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Georgia M. Barnes - St. Georges Island, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture skull</b> <b>825X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>C. expulsion of brain</b> (c) <b>Immediate</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>and accident</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>and accident</b>			
20c. TIME OF INJURY Month, Day, Year <b>10/13 19 58</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>State Highway</b>	
20f. (City or town) <b>Callaway</b>		20g. (County) <b>St Marys Isl</b>		20h. (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W.D. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10/15/58</b>	
EXAMINER'S NAME (Type) <b>Wm.D. Boyd, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/16/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes</b>	
22d. LOCATION (City, town, or county) <b>St. Georges Island, Md.</b>		22e. (State) <b>Md.</b>		22f. (County) <b>St Marys Isl</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>OCT 27 '58</b>		
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF  
MARYLAND

11-25

Decedent: John S. Brown  
Age: 45  
Sex: Male  
Race: White  
Marital Status: Married  
Occupation: Farmer  
Residence: 123 Main St., Baltimore, Md.  
Cause of Death: Heart Disease  
Manner of Death: Natural

Signature of Medical Examiner: [Signature]  
Signature of Coroner: [Signature]  
Date: 11-25-1935  
Place: Baltimore, Md.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completed and filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

11720

11726

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Great Mills</u>		LENGTH OF STAY (in this place) <u>20 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Great Mills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Arthur E. Norris</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Oct. 21, 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>? ? 1883</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS <u>Emma Charleston 2021 Booth St. Baltimore, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.1 IMMEDIATE CAUSE (A) <u>Cardiac failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cardiac block.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 12, 1957</u> , <b>to</b> <u>Oct 10, 1958</u> , <b>that I last saw the deceased alive on</b> <u>Oct 10, 1958</u> , <b>and that death occurred at</b> <u>night</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Charles Greenwell</u> <b>M.D.</b> <u>Leonardt</u> <b>DATE SIGNED</b> <u>md</u> <b>ADDRESS</b> (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/23/58</u>		NAME OF CEMETERY OR CREMATORY <u>Stx Holy Face</u>		LOCATION (City, town, or county) (State) <u>Great Mills, Md.</u>	
24. REC'D BY REGISTRAR <u>OCT 27 58</u> DATE		REGISTRAR'S SIGNATURE <u>W.C. Clarke</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.Clarke Mattingley</u> <b>ADDRESS</b> <u>Leonardt, Md.</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11721

Reg. Dist. No.

11727

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Marys</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>St. Marys</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>California</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. Marys Hospital</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Leroy</b> Middle <b>Edwin</b> Last <b>Stiefel</b>				<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>10</b> Year <b>19 58</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 27, 1911</b>		<b>9. AGE</b> (In years last birthday) <b>47</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>electrician</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Civil Service</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Kansas</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Marion Stiefel</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> [Yes, no, or unknown] <b>yes</b> [If yes, give war or dates of service] <b>WW 2</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Hertha H. Stiefel - California, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Fractured skull</b>  <b>825X</b>  <b>DUE TO</b>          Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO</b>          (c), stating the underlying cause lost.       </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>10/10/58</b> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>State highway</b>		<b>20f. (City or town)</b> <b>California</b> <b>St. Marys, Md.</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>Wm. D. Boyd</i>				<b>DATE SIGNED</b> <b>10/11/58</b>			
<b>EXAMINER'S NAME (Type)</b> <b>Wm. D. Boyd, MD</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10/14/58</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Arlington, Va.</b> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>P.B. Robinson - Leonardtown, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE OCT 15 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

